COMMUNITY HEALTH CENTERS: PROVIDING CARE FOR URBAN BLACKS

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Close your eyes for a minute and picture it—a low-income, urban black neighborhood. It is a community of shade trees and aging brick row houses, remnants of a more prosperous time 50 years ago or more. The look is typically Baltimore. With little imagination, however, you can transpose the scene to the baked-out slums of Los Angeles—flat, crumbling, stucco crackerboxes and, here and there, a forlorn scraggly palm tree. Or you can move to the sidewalks of Harlem or Philadelphia or Washington, DC, where squalor exists in the shadow of the White House. It shouldn't be hard to imagine, because poverty, illness, and disease are found throughout the nation. And blacks are suffering everywhere.

Smell the stench of stale urine in the gutters. Hear the frustrated screams of neglected children, already incapable of healthy anger. Walk gingerly among the piles of broken glass in the streets and vacant lots. Wade through the garbage in the alleys. Watch out for rats!

Peer through the basement window of that boarded-up house over there. You might see a junkie shooting up, trying vainly to escape his life. See the wino sleeping in the doorway. Greet the fat lady sitting on the steps. Take her blood pressure and be shocked. And cry for all those pretty, bright children with the chronic runny noses, nervous stomachs, and lead in their bloodstreams.

To be poor and black in America today is to know personal pain and physical discomfort. It is living uncomfortably close to the untimely death of acquaintances and family members. It is enduring problems like cancer and hypertension. It is, often, struggling along as a single parent against hunger, cold, unsafe neighborhoods, and the lack of adequate health care.

Dead-end jobs, unemployment, teenage parenthood, short life expectancy, bread lines, stress, and insecurity—these are common in the poor urban black community. In 1967, the National Advisory Commission on Civil Disorders reported that "the residents of the racial ghetto are significantly less healthy than most other Americans. They suffer from higher mortality rates, higher incidence of major disease and, in recent years, lower availability and utilization of medical services. They also experience higher admission rates to mental hospitals." Early in 1984, the Children's Defense Fund issued a report titled *American Children in Poverty*.[1] This report presents new statistics on an old injustice: blacks are three times more likely to be poor than whites, one in two black children is poor, one in every six black Americans is unemployed, one in two black youths is unemployed, and only 61 percent of all black men are now in the labor force.

At Constant Care Medical Center in Baltimore, Maryland, a myriad of serious health problems

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experienced by blacks are seen. Three of them stand out as most alarming. They are barometers of community health, and they demonstrate conclusively that there is no equal access to health care in this nation today. These health status barometers are cancer, hypertension, and infant mortality.

CANCER

A 1982 report titled *Cancer Facts and Cancer Figures,* published by the American Cancer Society,[2] states that studies conducted over several decades show that the cancer incidence rates for blacks are higher than for whites, and that blacks also have a higher death rate from cancer than whites. "In 1982," states the report, "the overall cancer incidence rate for blacks went up 8 percent, while for whites it dropped 3 percent." Cancer mortality has increased in both races, but the rate for blacks is greater than for whites. In the last 25 years, the cancer death rate for whites has increased 9 percent, whereas the black rate has increased 34 percent. Twenty-five years ago, the rates were the same.

One black in four suffers from some kind of cancer. According to the American Cancer Society, "the cancer sites where blacks have significantly higher increases and incidence in mortality rates include the lung, colon-rectum, prostate, and esophagus."[2] Esophageal cancer, long considered a disease mainly of men, declined in whites but increased dramatically in blacks, both men and women. The report also states that "the incidence of invasive cancer of the uterine cervix dropped in both black and white women, but the incidence in blacks is still more than double that in whites."[2]

Survival rates for cancer patients diagnosed between 1967 and 1973 were compared. More whites than blacks had cancer diagnosed in early, localized stages, when the chances of cure are best. In addition, a recent American Cancer Society survey conducted by a black-owned consulting firm showed that urban black Americans tend to be much less knowledgeable than whites about cancer's warning signals and less apt to see a doctor if they experience any of these symptoms. The blacks interviewed knew little about the three cancers that have seen sharp increase in mortality—colorectal, prostate, and esophageal. The survey also showed that blacks tend to underestimate both the prevalence of cancer and the chances of cure.

In both studies, most of the differences between whites and blacks were attributed to economic, environmental, and social factors, rather than to inherent biological characteristics. A higher percentage of blacks than whites are in low socioeconomic groups residing in old industrial neighborhoods; therefore, their risk of exposure to industrial carcinogens is increased. Also, the fact that blacks are frequently deprived of health education works against their being alert to the symptoms of cancer and obtaining early diagnosis and treatment.

When a community has a well-run, widely accepted, heavily used community health center in its midst, the residents have a fighting chance against cancer. Periodic checkups, frequent and deliberate health education sessions, and continuous references to the early warning signs of cancer, as well as appropriate, timely treatment make substantial inroads on cancer. The community health center, in fact, could become the nation's most effective offensive weapon in the black community's war on cancer.

HYPERTENSION

Each year high blood pressure causes hundreds of thousands more deaths from heart attacks and strokes for black Americans than for white Americans. Heart attacks and strokes in blacks are estimated to be 66 percent higher than for whites. Blacks have high blood pressure at one and one-half times the rate of whites.*

High blood pressure is of special concern for low-income blacks; it is present in 25 percent of

*According to the National Black Health Providers' Task Force on High Blood Pressure Education and Control

the population at age 17 and in 40 percent of the population over age 65. Less than ten percent of these blacks receive adequate medical care, as a common health care practice in the low-income black communities is to seek only episodic health care in a hospital emergency room. As in the case of cancer, many black hypertensives do not seek medical care until it is too late. To make matters even worse, hypertension is a "silent killer" often with no symptoms to motivate its victims to seek help. The estimated prevalence of undiagnosed elevated blood pressure for blacks over 18 in the State of Maryland is 78,370, or 14 percent of the total nonwhite population.**

The US Department of Health and Human Services reports that 50 percent of all men aged between 55 and 64 years suffer from high blood pressure as compared with only 30 percent of all white men. In all other age groups, hypertension is also higher for blacks than for whites. The survey indicated that men under 50 years of age, especially black men, frequently fail to have their blood pressure measured because they have no one constant source of medical care. When they do have their blood pressure measured, they are not given specific information about high blood pressure or its treatment. Further, many blacks have the erroneous belief that high blood pressure is caused by nervous tension, occurring only when they feel tense. Some other reasons why high blood pressure goes untreated are the lack of support from family and friends, the lack of motivation to change unhealthy nutritional habits, and the high cost of medication. As in the case of cancer, the best treatment for hypertension is health education and continuity of care. Community health centers have the potential to greatly reduce the prevalence and severity of hypertension among all black Americans.

Baltimore's Constant Care Medical Center is doing its part. There, the ethnic composition of the staff reflects the community served. There are no communication barriers and few difficulties relating to the patients' life styles. Blood pressures are monitored regularly in every medically related department. Constant Care models its hypertension treatment on the stepped-care regimen of the National Hypertension Detection and Follow-Up Project conducted in the late 1970s by the National Heart, Lung and Blood Institute. As a result, high blood pressure is controlled in a high percentage of Constant Care's regular patients.

**According to the Johns Hopkins Community Hypertension Education Project, December 1977

INFANT MORTALITY

It has been known for the past 20 years that the infant mortality rate is at least 85 percent higher, almost double the rate, for black babies than for white babies. Black babies are more likely to die because black mothers, who are more likely to be poor, simply cannot afford the prenatal care that would save their infants' lives. Babies born to women who receive late or no prenatal care are three times are likely to die in infancy as those babies born to women who receive adequate health care. Black babies in some medically underserved areas are dying at a rate almost four times the white infant mortality rate. Moreover, according to a report titled *The Widening Gap,* issued by the Food Research and Action Center in Washington, DC,[3] the gap between black and white infants is growing.

Another reason for early infant death is malnutrition of the mother while the baby is in utero and of the baby itself after birth. Also, some people are ignorant of life-preserving sanitation and safety practices that others take for granted. This problem is most serious in the case of adolescent mothers, and adolescent pregnancies are epidemic in the black community. Prenatal and postnatal counseling by health providers who understand the problem and *care* greatly increases a baby's chance to live. Family planning is also crucial, yet it is still unavailable to many urban teens.

It is a national disgrace that the infant mortality rate in some urban, predominantly black areas is higher than the rate in some underdeveloped countries and even in a few war-torn nations like El Salvador. Community health centers can help bring about a substantial reduction in infant mortality in their patient populations. At Constant Care Medical Center, there is a strong family

planning program that has reduced the number of adolescent pregnancies. There is also a weekly prenatal health education and counseling program to supplement the regular medical prenatal care. Birthing classes, child care classes, and ongoing counseling of parents all go a long way to prevent child abuse and ensure that the baby is properly fed, loved, and cared for. As a result, the infant mortality rate among Constant Care's regular patients is considerably lower than the horrendous figures previously cited.

COMMENTS

The causes of cancer, hypertension, and infant mortality are well documented. Yet, there is a racist view that the situation cannot change because blacks have a genetic predisposition to these health problems. It is a mystery why such an unscientific theory could be given any credence. All over the nation and around the world, when assistance reaches people it makes an impact and health statistics improve. It becomes ominous then, that the Reagan-appointed Secretary of Health and Human Services is commissioning still another study to probe the causes of black infant mortality. We already know why the incidence of infant mortality,[4] cancer, and hypertension is so much greater in the black community. The reasons are inadequate health care, poverty, and a lack of health education that the majority population receives as a matter of course.

We know *why* blacks are unhealthier. The question is, when is something going to be done about it? To compound the problem, black doctors are still in short supply. The black physician-to-population ratio is 27 physicians to 100,000 patients. For whites, the number of physicians is six times higher. Some white health care professionals discourage black patients or treat them mechanically; most blacks would rather do without health care entirely than see a doctor who treats them with disrespect.

All of these health disparities could be remedied if adequate health care were available. Community health centers have been bright spots on the bleak horizon. Community health centers are a product of the Great Society, which attempted to bring health care to the deprived. The community health center gives area residents accessible, empathic treatment, and offers a wide variety of health care services under one roof. Community health centers are located in low-income, medically underserved areas. However, since the Reagan administration took office, grants to community health centers have been steadily eroding.

Health care cost containment will not occur this year or the next. Inflation may be slowing, but health care costs continue to escalate. This situation is downright scary in the light of the prevailing high unemployment rate; a large number of Americans have lost income and health benefits. This, coming at a time when the administration in Washington seeks cuts in Medicare and Medicaid, poses a frightening challenge to Maryland's commitment to meeting the health care needs of its citizens. It is particularly distressing news to blacks.

Long-term and chronic health care are the most expensive types of care, and these are obtained in a hospital or in a hospital emergency room. When individuals receive adequate primary health care, many emergency room visits and hospital stays are prevented. Thus, primary care is not only the key to better health, but also the answer to health care cost containment.

High- and middle-income people usually get their primary care from a private physician in an office. Poor people, if they get primary care at all, receive it in a government-sponsored clinic. It is also common for the poor to doctor themselves with liniments, poultices, teas, and over-the-counter medications that are ineffective at best and dangerous at worst. Poor people using such treatments often show up in hospital emergency rooms.

Now all income groups have another health option—the community health center. Fifteen years ago, as a priority of the War on Poverty, the first community health centers began to operate in row houses, storefronts, and schools. Their mission was to reach the heretofore unreachable—the medically indigent who took their diseases for granted and died young. Since their beginnings, community health centers have come a long way. The quality of their care has always been excellent; now, however, they are combining business with altruism. They are still in a better position

than any other health care entity to reach the medically underserved.

There are 13 urban and rural community health centers spread over the State of Maryland. Community health centers are located in medically underserved areas designated by the state on the basis of high poverty, high infant mortality, high number of elderly residents, and too few primary physicians. All together, they serve 150,000 citizens. These health centers are partially funded by the Federal Bureau of Community Health Services to subsidize primary care delivery to a forgotten group: the working poor or "gray area" population that is ineligible for medical assistance, yet unable to pay the full cost of health care.[5]

The centers have an image problem. Much of the public is unaware of the centers' existence and purpose. Among some people, even among other health providers, there is a perception that they are impersonal clinics giving indifferent service.

Nothing could be further from the truth. Community health centers are both sensitive and personalized. They give high-quality, constant care that is rivaled only by that given by the family doctor. In fact, they are "families of doctors" with a wide variety of services under one roof.[6] These health providers easily collaborate on their patients' interrelated health problems. A single medical record minimizes the chance of writing incompatible or duplicate prescriptions or overlooking important symptoms. Providers have familiarity with local subcultures that gives them an edge in persuading patients to follow treatment regimens. Community health centers also specialize in health education to enforce the physicians' orders.

Unlike many hospitals, emergency rooms, and private practitioners, community health centers give preventive and comprehensive care. Community health centers emphasize wellness, not sickness. It is their aim to keep patients out of the hospital. They discourage unnecessary office visits and unnecessary diagnostic tests. They strive to bring the hospital emergency room back to its ideally intended use of treating bona fide emergencies and not crises brought on by neglect. Their success has been considerable; repeatedly, community health center patients have been shown to average fewer physician visits, fewer trips to the hospital emergency room and shorter hospital stays.[7] The centers' service is also inexpensive. Care delivered at a community health center costs 50 percent less than the same care delivered in a hospital outpatient department.[7]

Quality control and peer review are important to every community health center. The federal standards attached to the federal funds ensure high productivity and efficiency. Only 16 percent of a community health center's budget can be spent on administrative overhead. There are also standards for physician productivity (4,200 encounters per full-time equivalent physician), and cost per encounter (not to exceed $26).

Community health centers provide health care to patients not welcomed by any other provider. Hill-Burton Act of 1946 and Medicaid notwithstanding, poor black patients do not truly have the freedom to obtain the comprehensive, high-quality, constant care that they need. Community health centers are the answer. Working side-by-side with private practitioners and hospitals as a partner, not a competitor, there is no end to what they could accomplish for the healthier lives of American blacks.

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